



PATIENT SAFETY



Patient Safety activities encompass appropriate safety projects and error avoidance for Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice

The Molina Healthcare Patient Safety activities address the following:

- Continued information about safe office practices.
- Member education; providing support for members to take an active role to reduce the risk of errors in their own care.
- Member education about safe medication practices
- Cultural competency training
- Improve continuity and coordination of care between providers to avoid miscommunication
- Improve continuity and coordination between sites of care such as hospitals and other facilities to assure timely and accurate communication
- Distribute research on proven safe clinical practices

Molina also monitors nationally recognized quality index ratings for facilities from:

- Leap Frog Quality Index Ratings (www.leapfroggroup.org)
- The Joint Commission Quality Check® (www.qualitycheck.org)

Providers can also access the following links for additional information on patient safety:

- The Leap Frog Group (www.leapfroggroup.org)
- The Joint Commission (www.jointcommission.org)

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Features at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Guidelines
- Disease Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF and Pregnancy
- Quality Improvement Program
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Formulary & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement
(re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology

Molina Healthcare of Michigan

Please contact Provider Services at 1-888-898-7969 for written copies of all information on the website or if you need more information.

Practitioner Credentialing Rights: What You Need to Know



Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. Your responsibility, as a Molina Healthcare provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has responsibility to its providers to assure the credentialing information reviewed is complete and accurate. As a Molina Healthcare provider, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process;
- Nondiscrimination during the credentialing process;
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you;
- Review information submitted to support your credentialing application, with the exception of references, recommendations or other peer-review protected information;
- Correct erroneous information;
- Be informed of the status of your application upon request by calling the Credentialing Department at 1-888-898-7969;
- Receive notification of the credentialing decision within 60 days of the committee decision;
- Receive notification of your rights as a provider to appeal an adverse decision made by the committee; and,
- Be informed of the above rights.

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual. You may also review the provider manual on our website at www.MolinaHealthcare.com or call your Provider Services Representative for more details.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina Healthcare's clinical criteria includes McKesson InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.
- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. **To obtain a copy of the UM criteria used in the decision-making process, call our UM Department 1-888-898-7969.**
- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case please call the UM Department at **1-888-898-7969**.

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
3. UM decision makers do not receive incentives to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services was obtained in-network.
6. Some of the most common reasons for a delay or denial of a request include:
 - Insufficient or missing clinical information to provide the basis for making the decision,
 - Lack of or missing progress notes or illegible documentation, and/or
 - Requesting an urgent review when there is no medical urgency.

Molina Healthcare's UM Department staff is available during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call the **UM Department 1-888-898-7969**. You may also fax a question to **1-800-594-7404**. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

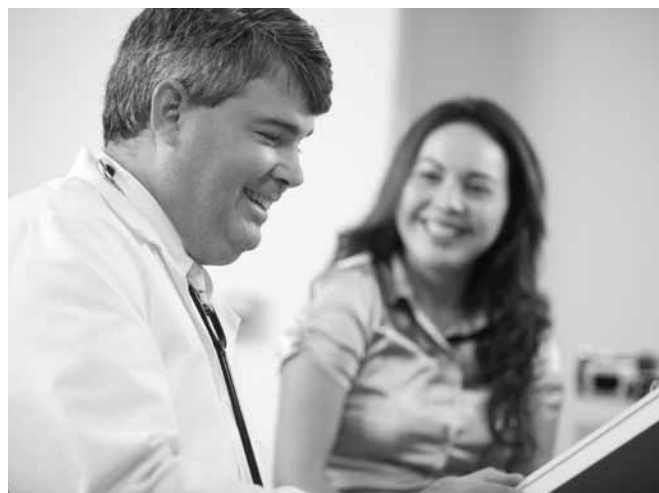
Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:00am - 5:00pm. Voice messages and faxes received after regular business hours will be returned the following business day.

Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those that have the most complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Complex Case Management Program is to:

- Conduct a needs assessment of the patient, patient's family, and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our patients to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure that they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and on-going care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family



If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call Toll Free **1-888-898-7969**.

Care for Older Adults

Many adults over the age of 65 have co-morbidities which often affect his or her quality of life. As this population ages, it's not uncommon to see decreased physical function and cognitive ability, and increase in pain. Regular assessment of these additional health aspects can help to ensure this population's needs are appropriately met.

- **Advance care planning** – Discussion regarding treatment preferences, such as advance directives should start early before patient is seriously ill.
- **Medication review** – All medications that the patient is taking should be reviewed, including prescription and over the counter medications or herbal therapies.
- **Functional status assessment** – This can include assessments, such as functional independence or loss of independent performance.
- **Pain screening** - A screening may comprise of notation of the presence or absence of pain.

Including these components into your standard well care practice for older adults can help to identify ailments that can often go unrecognized and increase his or her quality of life.

Drug Formulary and Pharmaceutical Procedures



At Molina Healthcare, the Drug Formulary (sometimes referred to as a Preferred Drug List or PDL) and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. This committee usually meets on a quarterly basis, or more frequently if needed. It is composed of your peers – practicing physicians and pharmacists from areas Molina Healthcare practitioners are located. The committee's goal is to provide a safe, effective and comprehensive Formulary/PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. They also evaluate and address new developments in pharmaceuticals and new applications of established technologies, including drugs. Molina Healthcare has two PDLs, one is for over-the-counter (non-prescription drugs) and the other for prescription drugs.

Medications prescribed for Molina Healthcare members must be listed in the Drug Formulary/PDL. Select medications may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the formulary choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. Printed copies of the Drug Formulary/PDL may be obtained by calling the Provider Services Department.

Additionally, the listing and prior authorization criteria are posted on the Molina Healthcare website at www.MolinaHealthcare.com.

Member Rights and Responsibilities

Molina Healthcare wants to inform its providers about some of the rights and responsibilities of Molina Healthcare members.

Molina Healthcare members have the right to:

- Receive information about Molina Healthcare, its services, its practitioners and providers and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Help make decisions about their health care.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about Molina Healthcare or the care it provides.

- Make recommendations regarding Molina Healthcare's member rights and responsibilities policy

Molina Healthcare members have the responsibility to:

- Supply information (to the extent possible) that Molina Healthcare and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Keep appointments and be on time. If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.

You can find the complete Molina Healthcare Member Rights and Responsibilities statement for your State at our website (www.MolinaHealthcare.com). Written copies and more information can be obtained by contacting the Provider Services Department at 1-888-898-7969.

Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to the provider and his/her patients. Guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

To request printed copies of Preventive Health Guidelines, please call 1-888-898-7969. You can also view all guidelines at www.MolinaHealthcare.com.



Disease Management Programs Improve Member Health

Molina Healthcare offers focused disease management programs that can significantly influence the health of our members and provide a variety of helpful services for those with chronic conditions such as asthma and diabetes.

Molina Healthcare offers the following Disease Management Programs to our members:

- **breathe with easesm** - asthma program for children and adults ages 2 years and over.
- **Healthy Living with Diabetessm** – diabetes program for adults age 18 years and over.
- **Heart Healthy Living** – cardiovascular program for members 18 years and older who have one or more of these conditions: coronary artery disease, congestive heart failure or high blood pressure.
- **Healthy Living with COPD** - COPD program for members who are 21 years and older who have emphysema and chronic bronchitis.

All disease management program interventions are targeted to the specific needs of each member. Members are automatically enrolled based on medical and pharmacy claims. Program materials include condition specific pamphlets and brochures, workbooks, patient logs, action plans, newsletters and other tools that educate the patient on how to manage their condition.

In addition, nurses or health educators reach out to patients and provide case management to those who will benefit the most from more frequent, in-depth follow-up. Physicians receive results of their patient's self

assessments and updates describing interventions and education offered to members. In addition, practitioners receive notifications and patient profiles on all members enrolled in any of the disease management program.

At each point of contact, members are encouraged to discuss their care with their provider and follow their plan of treatment. Other services available to members include having access to the 24 hour nurse advice line. Members can call and speak to a nurse for advice on any health problems. This program is voluntary, and members can stop participating at any time. If you have a Molina Healthcare patient you think will benefit from receiving educational materials or talking with a Case Manager, please refer them to our Disease Management Programs by calling our Member Services Department at 1-800-642- 4168.

You can find more information about our programs on the Molina website at www.MolinaHealthcare.com.



Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) provides the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement in members' health care and service. The Quality Improvement Committee (QIC) assists the organization to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determine further actions
- Designing effective and value-added interventions
- Continuously monitoring performance parameters and comparing to performance standards and benchmarks published by national, regional, or state regulators, accrediting organizations and internal Molina Healthcare threshold
- Analyzing information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: Claims, UM and/or Credentialing
- Confirming the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and Credentialing processes.

The QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare Members.

The effectiveness of QIP activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management.

Molina Healthcare would like to help you to promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina Healthcare website, please contact the Quality Improvement Department at the number below.

If you would like more information about our Quality Improvement Program or initiatives, or would like to request a paper copy of our documents, please call the Quality Improvement Department at 1-888-898-7969. You can also visit our website at www.MolinaHealthcare.com to obtain more information.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare, has established standards for medical record documentation to help assure the highest quality of care. Medical record standards promote quality care through communication, coordination and continuity of care, and efficient and effective treatment.

Molina Healthcare's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

For more information, please call the Credentialing Department at 1-888-898-7969.

Clinical Practice Guidelines

Clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines:

- Asthma
- Hypertension
- Diabetes
- COPD

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at 1-888-898-7969. You can also view all guidelines at www.MolinaHealthcare.com.



Advance Directives

Helping your patients prepare an Advance Directives may not be as hard as you think. Any person 18 years or older can create an Advance Directive. Advance Directives include a Living Will document and a Durable Power of Attorney document.

A Living Will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolongs life. A durable power of attorney names a person to make decisions for your patient if they become unable to do so.

The Caring Connections website provides you and your patients with free forms to help create an Advance Directive. The Caring Connections website address is: www.caringinfo.org.

For the living will document, your patient will need two witnesses. For a durable power of attorney document, your patient will need valid notarization.

A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to

a patient directive prior to service whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an Advance Directives and/or if there is a failure to comply with Advance Directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.



Behavioral Health

Primary Care Providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact CompCare at 1-800-435-5348.

Hours of Operation

Molina Healthcare requires that providers offer Medicaid members hours of operation no less than hours offered to commercial members.

HIPAA 5010 – The Clock is Ticking

“The only constant is change.” Heraclitus of Ephesus
With all of the highly publicized changes underway in healthcare due to the Health Care Reform bill (Patient Protection and Affordable Care Act of 2010), it is easy to overlook the less high profile, but still major changes coming down the pike under HIPAA: *the migration to the HIPAA 5010 transactions and the ICD-10 code sets.* With a compliance deadline of January 1, 2012, the clock is ticking for providers and health plans to complete their migration to the 5010 standards.

Why are the HIPAA Transactions Being Changed to Version 5010?

Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). More significantly, because the current 4010 versions of the HIPAA transactions cannot accommodate the ICD-10 code sets, Version 5010 is a prerequisite for the implementation of ICD-10.

How does the change to 5010 impact healthcare providers?

As HIPAA covered entities, providers and their vendors must migrate to the new 5010 versions of the HIPAA transactions that they conduct with health plans, such as the electronic claim and remittance advice. During 2011, providers must engage in external testing with health plans and other trading partners in order to help ensure a timely transition to the 5010 standards.

What is the 5010 Timeline?

Through the 5010 Rule, HHS has adopted the following Level I and Level II compliance dates to ensure full, successful and timely compliance by the healthcare industry:

Date	Compliance Deadline
Dec. 31, 2010	Level I compliance *
Dec. 31, 2011	Level II compliance**
Jan. 1, 2012	All covered entities must be 5010 compliant

* **Level I** compliance means that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design or build activities and internal testing.

** **Level II** compliance means that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.

What Should a Provider Do To Prepare For 5010?

- Visit the CMS and WEDI websites to obtain education material on the 5010 standard
- Contact your practice’s software vendors to find out if they are upgrading their software to support 5010 compliance;
- Upgrade your practice management and other software as required to a 5010 compliant version;
- Conduct internal software testing to verify that you can properly send and receive 5010 transactions;
- If you use a healthcare clearinghouse to send and/or receive 5010 transactions, contact your clearinghouse account representative to confirm that they are 5010 compliant and make arrangements to start testing; and
- If you exchange 5010 transactions directly with any health plans, confirm that the plan is Level I 5010 compliant and contact them to initiate external testing of the 5010 transactions.

Molina Healthcare’s 5010 Readiness

Molina Healthcare has achieved Level I compliance and is ready to test the 5010 HIPAA transactions with providers and other trading partners. For additional information regarding Molina Healthcare’s 5010 migration plans, please visit our website at www.MolinaHealthcare.com.



100 West Big Beaver Road, Suite 600
Troy, Michigan 48084

6384DM0311

Nurse Advice Line



The Nurse Advice Line is here to help. Trained nurses are available to serve your patients 24 hours a day, seven days a week. If your patients have any concerns about their health, our specially trained triage nurses are available to listen to their symptoms, provide medical advice and make referrals to an appropriate care setting. Encourage your patients to call our Nurse Advice Line for assistance.

Nurse Advice Line:

(888) 275-8750 (English)

(866) 648-3537 (Spanish)



Partners in Care

Molina Medicare of Michigan • Spring 2011



Inappropriate Prescribing in the Elderly - An Important Clinical Concern

Several studies have identified underlying causes regarding adverse drug event (ADE)-related admissions¹. In a review of studies, researchers found the following percentage of ADE-related potentially avoidable hospital admissions were attributed to¹:

- Patient adherence – 33.3%
- Inadequate monitoring – 22.2%
- Problematic prescribing – 30.6%

Additionally, Molina has reviewed our Medicare population for potentially harmful medications according to the Beers list. Overall, it was found 23% of Molina Medicare members filled a prescription for one or more potentially harmful medications during 2010, with the range across state plans ranging 17% to 32%.

In light of these findings, it is important to emphasize that **Molina Medicare has services to help support you in management of your Molina Medicare Members**. Molina Medicare has a medication therapy management program² through our pharmacy department in which our pharmacists complete a clinical assessment with your patients and we work to collaborate with you regarding medications and compliance. The Pharmacy department has additional information, please contact the department for assistance.

Molina Medicare has additional resources to assist you and your patients:

- Pharmacy line for Physicians: 1-888-483-0760
- Molina Medicare website – Formulary, Prior Authorization, Step Therapy Criteria
 - Located at www.MolinaMedicare.com (located in the Member site)
- Disease Management programs for Asthma, Diabetes, COPD and Cardiovascular diseases
 - Call Member Services Department at 1-800-642- 4168 for more information

New Coverage for Annual Wellness Visit

Effective January 1, 2011, Molina Medicare is offering coverage for annual wellness visits. This visit augments the benefit of the Initial Preventive Physical Examination (IPPE) with an annual visit that allows the physician and beneficiary to develop a personalized prevention plan. This prevention plan not only considers the age-appropriate preventive services generally available to Medicare beneficiaries, but additional services that may be appropriate due to the patient's individual health status. Molina Medicare is covering all Medicare covered preventive services, including the IPPE and the annual wellness visit to beneficiaries in 2011 at zero cost sharing.

¹ Curtiss, Frederic R., Fairman, Kathleen A.. Protecting Patients from Adverse Drug Events: Propoxyphene, PIMs and Drugs to Avoid in Older Adults. *Journal of Managed Care Pharmacy*. 2011;17(1):66.

² Members must meet certain criteria for enrollment in the medication therapy management program.

Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information can be faxed to Molina Medicare at: 1-800-594-7404.

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy: 1-800-665-3072.**
- **Behavioral Health** services and substance abuse treatment for Molina Medicare members can be arranged by contacting CompCare at **1-800-541-3647.**
- **Transportation** services for Molina Medicare Options Plus members may be arranged by calling **MTM at 1-866-867-3208.**
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at **1-888-275-8750.**

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **www.MolinaMedicare.com.**
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status & Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department at **1-888-898-7969** or Medicare Member Services at **1-800-665-3072** if you have questions regarding planned or unplanned transitions at: **1-800-665-1029.**